(8)

No. 97-689

In The

Supreme Court of the United States

October Term, 1997

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased,

Petitioner,

vs.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF FOR RESPONDENTS

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STATEMENT OF THE CASE

The instant appeal has a paucity of factual controversies but a myriad of complex and interesting legal issues involving COBRA continuation coverage when a former employee has an existing policy of medical insurance covering pre-existing conditions when his employment ends. Ironically, the former employee here has suffered no economic damages from Respondents' actions, and, in fact, is in a better financial position now than he would have been if he had received COBRA continuation coverage.

Petitioner's husband brought this action in four counts. Count I, the only Count before the Court, essentially alleges that he was a covered employee under the Moore Medical Group Health Plan, that his employment was terminated on July 16, 1993, that his COBRA continuation coverage was terminated and that this termination was improper because there was a difference ("gap") in character between Respondents' plan and Petitioner other group medical insurance plan. (App. pp. 14a-24a) The Respondents fully answered the Complaint and set forth ten (10) affirmative defenses as well as denying that the Petitioner's other group health plan underwritten by Aetna was secondary. Neither the Petitioner's employer, TWA, nor its medical insurer, Aetna Health Plans, is a party to this litigation.

Petitioner has made no claim that Aetna failed to pay any of the health claims during the COBRA continuation period. In fact, all of the claims were fully paid by Aetna. The only out of pocket expense Petitioner could conceivably have incurred was a weak allegation that the yearly deductible under the Aetna plan was "about" $350 greater than under the Moore plan[1].

1. Even this allegation is without evidentiary support. The record before the Court does not evidence that Petitioner incurred a higher deductible expense.

(App. 29a) This deductible difference is substantially less than what Petitioner would have spent to maintain COBRA continuation insurance under the Moore plan, as more fully discussed infra.

SUMMARY OF ARGUMENT

Under COBRA, a group health plan has the right to terminate continuation coverage to an otherwise qualified individual if that individual has a pre-existing health insurance provided by another group health plan. This is in keeping with the plain language of the Act, the intent of Congress as readily gleaned from the statute itself, the legislative history and the better reasoned decisions of three different appellate circuits.

COBRA was passed to give short-term protection to employees from the drastic consequences that can flow from losing their group health coverage due to an adverse employment consequence. Congress was also mindful of the cost burdens of this legislation to plan sponsors, and accordingly, has given them expansive powers to terminate COBRA continuation coverage. The case presents just one such situation. The employee was covered by another group health plan that did not contain a pre-existing condition clause and did not have any other significant gaps in coverage. In fact, the coverage of the policies was almost identical. On the date of the COBRA election was the first time that Respondents were permitted to terminate the continuation coverage.

The statute itself is curiously sparse. It can fairly be argued that many of its provisions are murky and ambiguous. If the Court determines the termination provision to be ambiguous, the only possible result is to rule that Respondents properly terminated the COBRA coverage of Petitioner's husband. To do otherwise defeats the "coherent statutory scheme of COBRA."

Additionally, if the Court adopts the "plain meaning" espoused by Petitioner, there will be some absurd and illogical results as well as some severe violations of public policy.

In essence, what the Petitioner seeks is double recovery. This attempt at double recovery is the only plausible explanation for the maintenance of this lawsuit. The Aetna Health Plan paid all of the medical expenses. She now seeks monetary relief from Respondents for those same medical expenses. Such a result is anathema, preposterous and absurd.

The Aetna Health Plan is not a party to this litigation, and it is Respondents' position that it is a necessary party to this litigation because if Respondents owe any monies it would be to reimburse Aetna and not to give the Petitioner a financial windfall. However, Aetna is not a party since it would receive nothing from this litigation since its policy of insurance was primary to the Respondents' policy. Under the coordination of benefits provisions under both plans, Aetna and Aetna alone would be responsible for all of the covered medical expenses. Respondents would be secondarily liable and since Aetna paid all of the medical expenses there is no expense for which Respondents are secondarily liable.

ARGUMENT

I.

RESPONDENTS PROPERLY TERMINATED PETITIONER'S COBRA CONTINUATION COVERAGE BECAUSE HE HAD GROUP HEALTH INSURANCE COVERAGE WITH NO SIGNIFICANT GAP IN COVERAGE.

The principal legal issue in the instant case is whether "spousal pre-existing coverage" obviates the necessity of providing COBRA continuation coverage to an otherwise qualified beneficiary[2]. This issue has been considered by five different federal appellate circuits. *See Geissal v. Moore Medical Corp.*, 114 F.3d 1458 (8th Cir. 1997); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989); *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558 (11th Cir. 1991); *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990); and *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, 51 F.3d 1308 (7th Cir. 1995) (J. Coffey, dissenting).

While there is not complete uniformity of opinion among these five circuits, each circuit, with the sole exception of the Seventh Circuit's majority opinion, expressly looked at the character of the pre-existing spousal health insurance. To varying

2. Petitioner raised a second question in the Petition for Certiorari concerning how courts are to determine if there is a gap in coverage. Petitioner has not briefed this issue and apparently has waived this issue. As will be shown, such waiver is understandable. It should be noted that Petitioner pled this matter as a significant gap case (Count I) and that is the pleading before the Court. App. 15a at ¶ 15. Petitioner has never sought to amend her Complaint. She did not plead the position that COBRA coverage must be given even if there is no significant gap. *Also see* Motion for Partial Summary Judgment. (App 25a).

degrees these courts have all determined whether a "significant gap" occurred between the coverage the former employee would have been afforded if given COBRA continuation coverage and the coverage under the spouse's pre-existing coverage. This is precisely what the Eighth Circuit held herein.

The well-conceived decision of the Eighth Circuit held that if pre-existing coverage exists, then the employee is not entitled to COBRA coverage unless there is a "significant gap" between the policies. Here, there is no gap whatsoever. To the contrary, Petitioner would have incurred more than two thousand dollars of additional expense if COBRA coverage had been afforded to him.

Petitioner understandably has relied heavily on the split decision in *Lutheran Hospital*, *supra*, because it is the only federal appellate decision that arguably supports her position. However, it should be noted that in that case as well as *Oakley*, supra, there was a substantial gap in coverage. Moreover, in *Lutheran Hospital* the court expressly stated that it was not concerned with cases such as the instant case, where the pre-existing coverage is "perfectly adequate". *Id.* at 1312[3]. Accordingly, this reliance is the proverbial "slender reed" discussed by Petitioner. (Pet. p. 42).

It is most telling that the only difference the Petitioner could elucidate in his affidavit between the coverage in the two medical insurance policies was the amount of the yearly deductible. The total theoretical maximum difference for the two years would be three hundred fifty dollars[4]. Petitioner's cost of COBRA coverage would have been almost three thousand dollars.

3. Even the Seventh Circuit majority gave attention to the character of the other policy while professing not to do so.

4. Because Petitioner has not asserted any out of pocket (Cont'd)

Even more telling is that the Petitioner cannot relate any factual situation (or even a hypothetical) where Aetna failed to pay, and the Respondent's plan would have paid. The reason for this is quite simple — there are no such gaps. Based upon the discovery supplied by Petitioner and Aetna Health Plans, all of the Petitioner's medical bills for "covered expenses" during the COBRA period of eighteen months were paid by the Aetna Health Plan. Petitioner has never made a claim at any stage of these proceedings that Aetna failed to pay any medical bills that Respondents would have.

Accordingly, this case is squarely on point with *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990) and clearly distinguishable from *Lutheran Hospital* and *Oakley, supra*. In *Brock*, the former employee participated in her employer's plan until her termination in February 1988. In addition, she was covered under her husband's group health insurance plan before and after her termination. After her termination, she sought to continue coverage under her employer's plan and paid the required premium. Her former employer denied her COBRA coverage after it discovered she was covered under her husband's policy. Petitioner brought suit for her subsequent medical bills. The appellate court affirmed the trial court's granting of summary judgment against the employer and aptly stated:

> This [1989] amendment further emphasizes Congress's concern that group health plan

(Cont'd)
expenses, we assume *arguendo* that he had to pay the Aetna $500 deductible in both 1994 and 1995 for a total cost of $1,000. If COBRA continuation insurance would have been provided, in 1995 Petitioner would have had to pay, at a minimum, the $150 deductible to the Moore health plan and the $500 deductible to the Aetna health plan for a total cost of $650. However, if any of the 1994 deductibles were incurred in the last three months of 1994, that amount would also be applied toward the 1995 Aetna deductible.

> participants and their dependents not be placed in a situation in which they suffer a gap in the character of coverage as the result of a "qualifying event" such as termination of employment. (citations omitted). In [Petitioner's] case, no such "gap" occurred. Before she left [her employer] she was covered under the [employer's plan] and her husband's plan for the type of medical problem for which she later claimed — and was paid — benefits. Thus, she was not entitled to elect continuation coverage under COBRA and, accordingly, is not entitled to the benefits she seeks.

Brock, 904 F.3d at 297.

Shortly after the *Brock* and *Oakley* decisions, the Eleventh Circuit in *National Companies, supra,* thoroughly addressed the statutory language of COBRA and the intent of Congress. In addressing the 1989 amendment that added the pre-existing condition language, the Court stated:

> This amendment, like the Oakley dicta, emphasizes the importance of the character of the coverage obtained by the beneficiary.
>
> Congress enacted COBRA because it was concerned about the fate of individuals who, after losing coverage under their employe's ERISA plan, had **no** group health coverage at all.

National Companies, 904 F.2d at 1569. [Emphasis added].

It was with this factual and legal backdrop that the Eighth Circuit determined the instant case. Concerning the interpretation of 29 U.S.C. § 1162(2)(D), the court stated:

> The quoted language was not meant to absolutely insulate from the exception persons who enjoy pre-existing insurance, but was merely intended to pinpoint the day on which the presence of that coverage becomes pertinent. In other words, it is only *after* the election date that an employee's status as a beneficiary under another group health plan will permit the termination of COBRA benefits.

Pet. App. A12. The court then proceeded to determine, using a *ex ante* analysis, that there was no significant gap and that Respondents did not violate COBRA by denying him continuation coverage.

II.

THE PLAIN MEANING OF THE COBRA LEGISLATION PERMITS AN EMPLOYER TO TERMINATE A FORMER EMPLOYEE'S COBRA COVERAGE IF HE IS COVERED UNDER ANOTHER GROUP HEALTH PLAN.

A. Statutory Construction Analysis

Obviously, since there is no gap, significant or otherwise, in coverage, the Petitioner necessarily comes before the Court to argue the sole proposition remaining available to her. Namely, that the plain language of the statute permits her double coverage and double recovery under both group health plans. Such a proposition simply has no legal support, and is frankly preposterous. The plain meaning of the statute militates against this dubious proposition. The statute clearly permits employers to terminate continuation coverage when there is pre-existing coverage under any other group health plan without a pre-existing condition exclusion.

Despite the clear and unambiguous language of the statute, Petitioner and amici have cited scores of cases for the proposition that the statute is the starting point of and the ending point absent an ambiguity or an absurd or illogical result. What they conveniently omit is that courts in construing legislation must view it as a whole and not just a snippet. A court must review the whole of an Act to determine a specific provision's meaning and the intent of Congress. *Conroy v. Aniskoff*, 507 U.S. 511 (1993) (Scalia, J. concurring). Here, Congress' intent is clearly apparent on the face of the Act without resort to legislative history or spurious "leaps of faith". The parties' failure to admit that an Act is to be construed in its context is most telling because to recognize the entirety of this most cardinal of the canons of construction obviates their belabored interpretation of the plain meaning of the Act.

Respondents will not engage in the mental gymnastics of differentiating each of the string of cases cited by Petitioner and amici involving statutory interpretation. Suffice it to say that the Respondents recognize that the exact words of the statute are controlling when sufficiently clear in context. However, in almost all if not all of the cited cases, the Court has looked to the statute as a whole to determine the plain meaning of the statute or to determine if there is an ambiguity.

> Our first step in interpreting a statute is to determine whether the language at issue has a plain and unambiguous meaning with regard to the particular dispute in the case our inquiring must cease if the statutory language is unambiguous and "the statutory scheme is coherent and consistent." (Citations omitted).

Robinson v. Shell Oil Co., 117 S. Ct. 843, 846 (1997) (Thomas, J.).

As the trial court properly noted, a court is required to look to the plain language of the statute, give significance to the statute as a whole, and examine the purpose and intent of a statute when deciding what its terms mean. Petitioner's App. at page 10, citing *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206, 217 (1984); *See also In Re Graven*, 936 F.2d 378 (8th Cir. 1991) ("When interpreting a statute we look not only to the express language but also to the overall purpose of the act.")

It simply does not take a crystal ball to divine the intent of Congress in enacting COBRA and in subsequently amending COBRA three times in a manner consistent with that intent. In fact, the long and consistent history of the amendments conforming the Act to the original purpose is remarkable. Congress wanted short-term protection for employees without any or inadequate health insurance while not saddling employers with too great of a cost burden. *See National Companies*, 929 F.2d at 1569-1570. In fact, the 1989 amendment expansively increased the situations where a group health plan could terminate COBRA continuation coverage, and at a minimum, codified that courts should look to the character of the other group health plan to determine if it is adequate for the employee. Obviously, if Congress were not concerned about the cost burden on employers, it would not have provided group health plans with such a broad ability to terminate coverage. The majority in *Lutheran Hospital*, *supra*, failed to take these salient facts into consideration in making its holding.

It is apparent that Congress was faced with a number of competing interests when it enacted COBRA legislation in 1986. In the face of these competing interests, Congress' purposes in passing COBRA and the three relevant amendments are clear from even a cursory reading of the Act without resort to legislative history. COBRA was designed to protect those who

lose their coverage under a group health plan due to an adverse employment consequence. As stated previously, Congress recognized the cost burden to employers which is reflected in the short term nature of the coverage; the ability to charge a premium up to 150 percent of a plan's costs, and the expansive ability to terminate continuation coverage. Congress' intent is further illustrated by the three amendments to 29 U.S.C. § 1162(2)(D).

The 1986 amendment adding "*as an employee or otherwise*" clearly expanded the grounds for terminating coverage. In 1989 it codified the gap issue by stressing the character of the other group health plan policy when it added the language, "*which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary*". This amendment also illustrates the point that Congress' did not intend to discriminate against any group of qualified beneficiaries.

Further, the last amendment with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPA) again greatly expanded the universe of situations where plans can terminate coverage. Group health plans must credit a beneficiary with the prior coverage period in the waiting period for a pre-existing condition exclusion — which cannot extend more than twelve months. Pub. L. No. 104-191, §§ 101, 102, 401. Congress again clearly demonstrated its cost concerns with COBRA and demonstrated where the burden of that cost should be placed — squarely on the policy of the other carrier and not on the economic back of the COBRA provider.

Respondents cannot over emphasize the primary importance of the cost shifting analysis in the overall scheme of COBRA. The act is in derogation of common law, and it imposes substantial financial burdens on employers. Congress recognized

these costs concerns and accordingly, took appropriate measures to lessen the economic impact on employers, principally by permitting liberal terminations. There is a common theme throughout its history that COBRA coverage should be terminated as soon as possible and that the cost of a beneficiary's medical expenses should be shifted to the group health plan that is receiving the benefit of an employee. HIPA clearly illustrates Congress' intent in this regard. Without attaching primary importance to the cost shifting provisions of COBRA any analysis of the Act, taken as a whole, fails.

Similarly see, *Teweleit v. Hartford Life and Accident Insurance Company*, 43 F.3d 1005 (5th Cir. 1995) where the Court revisited the law on COBRA continuation coverage. After reviewing the reported cases to date, the court succinctly summarized the status of those cases:

> Brock and National Co. and, to a lesser extent, Oakley have voiced a common interpretive theme of COBRA coverage: its purpose is to eliminate gaps in insurance coverage that could accompany changes in or loss of employment. These statements are not just a theme, however, but the enacted will of Congress in language sufficiently clear to achieve its purpose.

Teweleit, 43 F.3d at 1008.

If Congress intended such an expansive and liberal reading of COBRA as urged by Petitioner, it could easily have drafted a clause concerning the liberal interpretation of the Act. Congress has often inserted provisions of this nature. Given the strength of the various competing interests involved, it is highly unlikely that failing to insert such a clause was the result of oversight or a scrivener's error. Obviously, Congress did not view this as a

situation warranting a liberal and expansive reading of the statute in favor of the beneficiaries.

Contrary to Petitioner's protestations, Respondents' position is consistent with the intent of Congress and is clearly consistent with the statutory language. The continuation coverage provisions of the Employee Retirement Income Security Act of 1974, more specifically 29 U.S.C. § 1162(2)(D) presently provides that COBRA coverage can be suspended on:

> The date on which the qualified beneficiary first becomes, after the date of the election —
>
> (v) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary [other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of Title 26, part 7 of this subtitle, or title XXVII of the Public Health Service Act [42 U.S.C.A. 300gg et seq.])][5], or
>
> (v) In the case of a qualified beneficiary other than a qualified beneficiary described in section 1167(3)(C) of this title, entitled to benefits under title (XVIII of the Social Security Act [42 U.S.C.A. §1395 et seq.])

Under the plain terms of the statute, when a covered individual has other pre-existing coverage, his COBRA coverage can be suspended on the day he elects COBRA. This

5. Bracketed clause was not in effect at the time this cause arose.

interpretation does not ignore the plain meaning of any of the statute's terms. Petitioner's interpretation, however, relies on the fallacy that because the statute points to the first date after the date of election to determine suspension of coverage that other coverage must necessarily originate after the election date. This is a complete non-sequitur. The statute only discusses the first time when a suspension of coverage can occur[6]. It never defines when the other policy must initiate coverage. Moreover, it also should be noted that Petitioner's husband only **truly** (primarily) became covered by the Aetna Health Plan when the COBRA was terminated.

This reasonable construction of the statute does not violate any statutory construction principles and is certainly not usurping the lawmaking powers of Congress. Instead, it gives effect to the plain meaning of the statute particularly when viewed as a whole. Further, it does not require the suspension of common sense nor does it require invading the province of Congress.

This issue is somewhat analogous to the issue faced by the Court in *Milwaukee Brewery Workers' Pension Plan v. Jos. Schlitz Brewing Co.*, 513 U.S. 414 (1995) (Breyer, J.).

> . . . [T]he calculation date is none of those things; it is a date chosen simply for ease of administration; and ease of administration does *not* require choosing the same date for interest-accrual purposes.

Id. at 428. Here too, the language concerning the election date is a date chosen for ease of administration. It is axiomatic that a

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6. The government implicitly admitted as much in its Brief by arguing that that the rights to COBRA during the sixty day election period are mandatory and that it can only be suspended after the election.

group health plan cannot terminate something that has never been elected.

This statutory requirement makes sense and is consistent with the "statutory scheme" of COBRA and is consistent with other legislation. Similarly, the Americans for Disabilities Act (ADA), 42 U.S.C. § 12000, *et seq.* permits prospective employers to request a medical examination of the prospective employee only after he has already been offered a position. Then, on the basis of the medical examination, the prospective employer can rescind the employment offer if the employee fails the medical examination.

Accordingly, requiring group health plans to give COBRA notice and then terminating coverage makes imminent sense, irrespective of the specific date the coverage was obtained. Moreover COBRA requires a plan administrator to "notify the beneficiary of his rights under this subsection." 29 U.S.C. § 1166(4). The typical notice states that coverage under any other group health plan is a terminating event. The time lag allows a qualified beneficiary to review his options and seek advice if necessary. Further, without the actual notice and express election of COBRA, there would be no safeguard for employers. Former employees like Petitioner's husband, with the benefit of 20-20 hindsight, will bring lawsuits against their former employers alleging they would have elected COBRA if given the opportunity. Employers would have no defense against this after the fact declaration. This would truly be a morass if employees, using an *ex post* analysis can declare that they should have been given a COBRA election. This evil is eliminated with (1) notice of the beneficiary's rights; (2) affirmative election by the beneficiary; and (3) termination by the plan — much as it does with medical exams under the ADA.

Moreover, the election period makes sense and is not a "charade" for even those with wonderful pre-existing coverage.

COBRA does not require providing only health insurance. If a group health plan offers separate dental and/or vision plans, the beneficiary may elect any or all of the plans. *See Lutheran Hospital*, 51 F.3d at 1313. Accordingly, a qualified beneficiary with wonderful pre-existing medical coverage still has the absolute right to elect COBRA continuation coverage for the dental and/or vision portions.

Furthermore, if the plain terms of the statute mandate Petitioner's interpretation, it is remarkable that four different appellate panels have ignored this mandate. *See National Companies*, 929 F.2d at 1570. ("Thus, it is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does the coverage take effect"); *Lutheran Hospital*, 51 F.3d at 1316 (J. Coffey, dissenting) ("There is nothing in the language of this statute to suggest that termination of the right to COBRA coverage cannot occur simultaneously with the triggering of the right to coverage, if a person continues comparable coverage under a pre-existing health plan.")

Petitioner and amici required approximately 100 pages to allegedly demonstrate that the plain language of the statute supports their position. The natural inference of such lengthy protestations is that it simply does not plainly support their positions. As Shakespeare wrote: "He that doth protest too much." Lending further support to this proposition is the Government's position. In 1986 it issued its proposed regulations contemporaneous with the passage of COBRA. In those regulations pre-existing coverage and Medicare eligibility are terminating events[7]. Now some 12 years later as this issue comes before the United States Supreme Court, the Government

7. The proposed regulations issued by the Internal Revenue Service, specifically answers to questions 15 and 38. 52 Fed. Reg. 22730 (1987).

does an about face and incredibly goes to great length protesting that the statute can have only one interpretation — the one in contradiction to its long held position. The government's new position (apparently for purposes of this lawsuit) obviously should be given no deference in determining this issue. *Estate of Cowart v. Nicklos Drilling Co.*, 506 U.S. 469, 476 (1992) (Blackmun, J. dissenting). Under these circumstances the government wisely has not urged deference to its position.

How amicus curiae can argue in support of its position that the statute is a clear as possibly could be is incredulous. (AARP p. 7). It is only plainly in Petitioner's favor if one has such a bias toward employee rights that one sticks his head in the sand and ignores the language and purposes of the Act. At best, it speaks rather awkwardly.

B. Legislative History Analysis

Moreover, Respondent's position is consistent with the legislative history behind COBRA. While Respondents are not stressing the legislative history, a short review is appropriate. *See Curtiss-Wright v. Schoonejongen*, 514 U.S. 73, 81 (1995):

> Ordinarily, we would be reluctant to indulge an argument based on legislative purpose where the text alone yields a clear answer, but we do so here because it is the argument the Court of Appeals found pervasive.

Congress enacted the COBRA amendments to ERISA in response to

> reports of the growing number of Americans without **any** (emphasis added) health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay.

H.R. Rep No. 241, 99th Cong., 2d Sess. 44, reprinted in 1986 U.S.C.C.A.N. 42, 579, 622. It was also prompted by the "staggering budget deficits now facing the United States." S. Rep No. 146, 99th Cong., 2d Sess. 3, reprinted in 1986 U.S.C.C.A.N. 42, 43.

Another reason for reviewing the legislative history is that COBRA is a curiously brief statute. It is an afterthought to ERISA with its "comprehensive and reticulated statute." *Nachman Corp. v. Pension Benefit Guarantee Corp.*, 446 U.S. 359, 361 (1985). This author's experience has been that the statute has not been of great assistance in answering client's questions. Since it is so brief and has created so much confusion, it is an anomaly to the remainder of ERISA[8]. Accordingly, the general rules of ERISA construction are not entirely appropriate. *Cf., American Tobacco Co. v. Patterson*, 456 U.S. 63 (1981) (White, J.) referring to the vast amount of labor that went into Title VII of the Civil Rights Act and holding that: "The plain language of § 703(h) is particularly cogent in light of the circumstances of its drafting." *Id.* at 68-69.

Thus, for Petitioner to maintain that COBRA supports her attempt to obtain duplicative insurance coverage flies in the face of Congress' purpose to help those without any coverage. As such, the Court must reject Petitioner's strained interpretation. Considering the plain meaning of the statute and the relevant legislative history, the decision of the Eighth Circuit must be affirmed.

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8. *See* footnote 11 of Petitioner's Brief. While the author was actually bemoaning the lack of legislative history for guidance, the salient point is the confusion the sparseness of the statute has created.

III.

ASSUMING *ARGUENDO* THE PLAIN MEANING DOES NOT PERMIT TERMINATION, THEN THERE IS AN AMBIGUITY THAT MUST BE RESOLVED IN RESPONDENTS' FAVOR.

The Respondents maintain that the plain meaning of COBRA permits termination of continuation coverage if there is coverage by any other group health plan. However, Respondents are not unmindful that the termination provisions of § 1162(D) could fairly be labeled by the Court to be murky or ambiguous.

> The plainness or ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, and the broader context of the statute as a whole.

Robinson v. Shell Oil Co., 117 S. Ct. at 846 (1997) (Thomas, J.) citing *Estate of Cowart v. Nicklos Drilling Co.*, 506 U.S. 469, 477 (1992); *McCarthy v. Bronson*, 500 U.S. 136, 139 (1991).

Considering the split of authority among the five appellate circuits who have interpreted § 1162(2)(D), a finding of ambiguity arguably is almost mandated. Each of the circuits have reviewed the plain meaning of the section and have made differing interpretations. This is not dangerous circular logic as posited by Petitioner at page 46. If just one judge had a differing position, this argument would not be advanced. However, this section has been reviewed by at least 21 different appellate justices. Sixteen justices determined the plain meaning of COBRA permitted terminations if there was pre-existing coverage under any other group health plan while five held that it did not.

Moreover, is there any question that Congress could have been clearer and more comprehensive in drafting the COBRA legislation? *Milwaukee Brewery Workers'*, 513 U.S. at 428. Very few of its terms are defined. It does not state when, for COBRA purposes, a qualified beneficiary "becomes covered" under another group health plan. Is it when the other coverage becomes primary B which is what it clearly is for those who receive insurance only after the election date? Is it for COBRA purposes the exact moment that the election is made? Strong arguments can be made to support each of these meanings. Or is it the Petitioner's interpretation that the policy must originate only after the election date? Further, the statute is silent as to when the other policy has to be obtained.

> Where a statutory term presented to us for the first time is ambiguous, we construe it to contain that permissible meaning which fits most logically and comfortably into the body of both previously and subsequently enacted law. See 2 J. Sutherland, Statutory Construction § 5201 (3d F. Horack ed. 1943). We do so not because that precise accommodative meaning is what the lawmakers must have had in mind (how could an earlier Congress know what a later Congress would enact?), but because it is our role to make sense rather than nonsense out of the *corpus juris*.

West Virginia University Hospitals, Inc. v. Casey, 499 U.S. 83, 100-101 (1990) (Scalia, J.).

As Respondents stress throughout, their position is "coherent and consistent with the COBRA statutory scheme." Accordingly, if the statute is deemed to be ambiguous, the only sensible result is to rule that COBRA continuation coverage may be terminated when the beneficiary has other group health

plan coverage without a significant gap regardless of the artificial concept concerning the exact moment of obtention of that coverage. Any other result simply defeats the "consistent and coherent statutory scheme" of COBRA. *Robinson*, supra.

IV.

THE INTERPRETATION OF THE STATUTE POSITED BY PETITIONER YIELDS ABSURD AND ILLOGICAL RESULTS.

Petitioner's strained interpretation of the COBRA legislation not only flies in the face of the reasonably plain meaning of the Act and the intent of Congress, but also creates some absurd and illogical results. Petitioner admits at Section V of her Brief that an absurd result is an exception to the "plain meaning" rule. Adopting the position advocated by Petitioner will yield some extremely illogical results. These illogical results are best illustrated by hypothetical situations.

Situation 1:

> Employee leaves employer on January 1. On January 15, employee is given his COBRA election notice advising that he has sixty (60) days to elect COBRA continuation coverage. On February 1 employee becomes covered under his new employer's group health plan that does not contain a pre-existing condition clause. On February 2, employee elects COBRA. Under the Petitioner's interpretation, the employee would be allowed to keep his COBRA coverage since he became covered before the COBRA election. In no manner does this preserve the "status quo" or effectuate Congress' intent. It just creates another double coverage situation wherein the employee is trying to cash in on his double medical coverage.

Situation 2:

> Same situation as situation 1 above, except that on February 1, the employee turned 65 and became Medicare eligible. Note that Medicare terminations are included in the same subsection as the one before the Court. Again, the employee would be eligible for COBRA since he became eligible for Medicare before the election date.

These situations clearly demonstrate the absurd results that will flow from the interpretation urged by the Petitioner. These situations certainly do not maintain the "status quo" as argued by the Petitioner in support of her position. Nor do they support any other expressed intention of Congress. The former employee now has the luxury of two policies where before the qualifying event he only had one. There simply is no plausible argument why Congress would desire such a result. It clearly shows that Petitioner's supercilious reliance on the exact moment of obtention of the other policy to determine whether COBRA coverage may be terminated is a red herring.

It is further an absurd proposition to believe that Congress intent was to bestow a financial windfall on people with wonderful pre-existing coverage, There is no logical reason that the small subset of people with wonderful pre-existing policies are singled out for such preferential treatment. *Lutheran Hospital*, 51 F.3d at 1312. Assuming that Congress acts rationally, there is no possibility that it would have enacted legislation that discriminated so greatly in favor of such a small subset of the population. It is axiomatic that Congress is presumed not to have discriminated and to have acted reasonably. In fact, the Act contains an anti discriminatory provision requiring COBRA coverage to be identical to that provided current employees[9]. 29 U.S.C. § 1162(1).

9. The majority in *Lutheran Hospital*, 51 F.3d at 1313 (Cont'd)

Perhaps the most absurd result is in situations like the present where the employee would have the benefit of two gilt edged insurance policies and be entitled to a double recovery. Congress did not enact COBRA to create a windfall for a few beneficiaries. It passed COBRA and the three amendments to protect those without any or inadequate health insurance. That is the status quo that was preserved. Congress certainly was not concerned with this situation where the other coverage was "perfectly adequate."

V.

PUBLIC POLICY CONSIDERATIONS SUPPORT THE INTERPRETATION URGED BY RESPONDENTS.

Petitioner made an inartful and half-hearted attempt to invoke public policies reasons to support her position. She claims that Congress was "probably concerned about the potential impact on families of absorbing even part of the cost of a medical crisis." (Pet. p. 47). Such an argument is extremely curious since on the facts of the instant case, it supports the Respondents' position. Neither having double coverage or single coverage would have resulted in the Petitioner's family having to absorb any of the costs of medical treatment. The issue is not about Petitioner absorbing costs but about Petitioner receiving a windfall or which group health plan is to bear the medical costs.

However, there are good and substantial public policy reasons supporting the Respondents' interpretation. First and

(Cont'd)
mistakenly took the identical coverage requirement to extrapolate that double coverage should be permitted. The more reasoned position was cogently set forth by the Eighth Circuit below at footnote 9. (A-11).

foremost, the interpretation clearly reflects the plain meaning of the statute and gives effect to the express intent of Congress. Secondly, Congress has spoken repeatedly as to where it believes the cost burden should be placed, and as discussed earlier it is not with the COBRA provider. The cost burden should, in the first instance, be borne by the sponsor of a group health plan who is receiving an economic benefit by having a gainful, productive employee. *See Hermann v. Cencom Cable Assocs.*, Inc., 978 F.2d 978, 979 (7th Cir. 1992) ("Health insurance care as a fringe benefit for productive workers is one thing, and as a gift to persons who have been laid off or fired is another") *Also see* dissent in *Lutheran Hospital*, 51 F. 3d at 1318 where Judge Coffey correctly stated that issue is which insurance company pays the bill.

In the same economic vein, the cost to small employers of adopting Petitioner's position would be staggering. COBRA continuation coverage is extremely expensive to group health plans[10]. This is particularly so for small employers (COBRA covers group health plans as small as 20 participants) who will need to amortize the staggering cost over a small group. If the costs become too great, small employers will think seriously about whether they should continue to provide group health insurance coverage to their employees. Such discontinuations are not in the public interest or in keeping with the intent of Congress to reduce the "staggering budget deficits facing the United States". Also, it will increase the cost of COBRA continuation coverage to those beneficiaries who actually need COBRA's protection but may not be able to afford it due to the increased cost.

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10. Sarah Rudolph Cole, "Continuation Coverage Under COBRA: A Study in Statutory Interpretation," 22 N.D. Journal of Legislation 195, 198 (1996). The undersigned appreciates this excellent article by Professor Cole and acknowledges borrowing heavily from it.

It would be a incongruous result for the Petitioner to receive a windfall while the decision eventually causes untold numbers of employees to lose their health insurance coverage. The dramatic financial consequences imposed on those workers with lost insurance will ultimately flow to the government or the nation's hospitals as the medical insurers of last resort. Moreover, the idea of a double recovery is anathema to our jurisprudential thought. COBRA health insurance is not a medical lottery designed to greatly assist the few fortunate enough to have wonderful double coverage at the expense of all others.

There is another major public policy concern with the construction advocated by the Petitioner. While Petitioner and amici voice concern over the "morass" caused by employer's having to make determinations about the character of the other group health plan, a real evil lies elsewhere if the Court adopts the Petitioner's interpretation. Namely, a bidding war erupting between the COBRA provider and the sponsor of the other group health plan attempting to influence which coverage the beneficiary elects. Is it in the public interest for the other provider to "bribe" a qualified beneficiary to elect COBRA so that person's claims will not be included in its experience rating?

VI.

THE SIGNIFICANT GAP TEST IS NOT RELEVANT TO THIS CASE.

As discussed earlier at footnote 2, Petitioner has apparently waived the second issue set forth in her Petition for Writ of Certiorari, namely the application of the significant gap rule as set forth by the Eighth Circuit. Any broad discussion herein of significant gap will be dicta since there simply was no gap in this case. Accordingly, Respondents do no intend to belabor the point.

In 1989 Congress amended 29 U.S.C. § 1162(2)(D)(I) by adding, "which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary." This amendment codified that whether a plan is allowed to terminate COBRA coverage depends upon the character of policy of insurance given by the other group health plan. Accordingly, "significant gap" is not some artificially created judicial boondoggle as some have intimated but is in line with the clearly expressed purpose of the Act. In essence it is nothing more than a determination whether there is a pre-existing condition exclusion or limitation. Further, the House of Representative in its report made express reference to the term "significant gap." H.R. Rep No. 101-247, 101st Cong., 1st Sess., reprinted in 1989 U.S.C.C.A.N. 1906, 1943. Concern by Congress over the character of the other insurance is a recurring theme.

Petitioner and amici's dubious concerns over the "morass" a significant gap analysis allegedly creates for employers is noted but has no basis in fact or law. First, this is a policy issue and as such is not the province of the Court. Ironically, Petitioner and amici belabored this point *ad nauseum* in their Briefs. Secondly, an employer who wants to escape this "morass" can voluntarily provide COBRA. An employer may voluntarily offer COBRA coverage to an ineligible beneficiary since the Act only sets out minimum requirements and certainly has no prohibition against benefits greater than the minimum.

Thirdly, this "morass" is present in the much greater number of cases involving what Petitioner would refer to as health coverage only expressly written after the employee elected COBRA. The plan administrator now has to look at the coverage of the other insurance to determine whether there is pre-existing coverage and/or a gap between the policies[11]. If plans want to

11. The Government's position is extremely curious. At footnote 14, page 27, it argues that the character of the subsequent (Cont'd)

wade into this "morass", the plan administrator is trained and paid to do just that. Accordingly, this "morass" is simply not an issue of concern to the Court.

VII.

THE PETITIONER LACKS A COGNIZABLE CLAIM FOR DAMAGES OR ANY OTHER RELIEF.

Since Petitioner has no claim for compensatory damages under ERISA, she has no legally cognizable claim under Count I of the Complaint. 29 U.S.C. § 1132(A)(1)(a). Judge Noce (A-24) correctly ruled that Petitioner has no claim for compensatory damages[12]. Accordingly, the real party in interest is Aetna Health Plans and/or TWA and neither is before the Court. Respondents cannot comprehend what type of relief the Petitioner is statutorily entitled to recover from them on Count I.

In discussions with Petitioner's counsel, he has indicated that Petitioner seeks a monetary judgment in her favor and

(Cont'd)
policy is immaterial as long as there is no pre-existing condition exclusion. This argument is diametrically opposite its position in this case of preserving the status quo. According to this line of reasoning, Congress was only concerned about a pre-existing condition clause and not whether there were any gaps in coverage. In essence, significant gap is simply a determination whether there is a pre-existing condition exclusion in the other policy.

12. Petitioner correctly noted in the Memorandum to the trial court at page 19, footnote 8, that compensatory damages are not recoverable under this type of action. In fact, "make whole" is the only remedy under these types of ERISA actions. *Cf.* 26 U.S.C. § 4980B(g)(4).

against the Respondents for the full amount of the covered medical expenses.[13] She maintains this position even though all such expenses have been paid by Aetna and neither the Respondents' health plan nor the TWA health plan permits a beneficiary double recovery of medical benefits under their respective coordination of benefits provisions[14].

Arguably, if the Court were to hold that Respondents should have provided COBRA coverage to Petitioner and that such policy was **primary** to Aetna's policy, then Aetna should be reimbursed by Respondents for all "covered expenses" incurred by Petitioner during the COBRA period. However, there simply is no support for the proposition that Respondents' policy would be primary to that of Aetna's. The National Association of Insurance Commissioners holds that COBRA insurance is secondary to other coverage. (The COBRA policy only becomes primary in the event of a pre-existing condition clause and then only primary as to the pre-existing condition.) NAIC Model Rule 120. In accordance are the coordination of benefit rules adopted by both Missouri and Connecticut, the only two states with any nexus to this case. Mo. Code of State Regulations, 20 CSR 400-2.030(4)5 and Conn. Admin. Code, tit. 38 §§ 38-174-1 to 38-174-7. According to the NAIC thirty eight states have adopted the NAIC Model Rule 120. NAIC, Model Laws, Regulations & Guidelines, Vol. 1.

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13. A similar statement was raised in Respondents' Brief to the Eighth Circuit and was not rebutted by Petitioner.

14. Petitioner mistakenly believes that she is entitled to recover and retain the full amount of her husband's medical bills from Respondents. In essence, she is seeking a huge windfall. This is hardly the sort of remedial measure Congress intended when it enacted COBRA. Only this unmitigated attempt at double recovery can explain the Petitioner's motivation to prosecute a lawsuit where a successful result will cause her to pay the Respondent almost $3,000.

Since Aetna's policy is primary and since it has paid all of the covered medical expenses, there are no expenses for Respondents to pay to either Petitioner or Aetna. Accordingly, absent a determination of the primacy of Respondents' health plan, there is simply no relief that can be granted as to Count I. At best, a successful result for Petitioner herein will be a pyrrhic victory.

The Petitioner will owe Respondents Two Thousand Six Hundred Seventy Three Dollars and eighteen cents ($2,673.18) for eighteen (18) months of COBRA coverage (18 months times $148.51 per month). Accordingly, the undersigned finds it incredible that Petitioner pursues this litigation. A successful result will cost Petitioner $2,623.18 while an unsuccessful result will have no beneficial economic impact on her or on any other entity. The Petitioner's motivation can only be described as highly suspect.

Therefore, the Petitioner, having no possibility of financial reward from this litigation, lacks any recognizable basis to pursue this matter. Only Aetna and/or TWA would have any financial stake in the outcome of Counts I. Accordingly, the nature of the relief ultimately sought by Petitioner is difficult to comprehend.

Tellingly, all of the COBRA cases involving pre-existing coverage, including the one Petitioner principally relies upon, *Lutheran Hospital*, 51 F.3d at 1308 (7th Cir. 1995), had the pre-existing medical insurer as a named party.

> COBRA insurance is not, nor has it ever been intended to provide adjunct or double health insurance coverage for those who are covered under another pre-existing policy. Mrs. Isch [the Petitioner] and Lutheran Hospital are named Petitioners in this

> action when in truth and in fact, the argument is between Associated and the Teamsters, two insurance companies who are attempting to avoid the payment of her medical expenses.

Dissent, Lutheran Hospital, 51 F.3d at 1315 (J. Coffey dissenting).

Accordingly, summary judgment should be granted as a matter of law because the Petitioner lacks any recognizable claims under Count I. Otherwise, a very real possibility of a double recovery for Petitioner exists[15]. It is black letter law that a party must have a justiciable interest to protect in order to have standing to maintain a suit.

VIII.

THE PETITIONER'S AFFIDAVIT RELIED UPON SO HEAVILY BY THE PETITIONER IS INCOMPETENT, IN PART, AND SHOULD BE STRICKEN PURSUANT TO RULE 56(e) OF THE FEDERAL RULES OF CIVIL PROCEDURE.

The vast majority of James Geissal's affidavit is either speculative, conclusory or conjectural in nature and should be stricken pursuant to Rule 56(c) of the Federal Rules of Civil Procedure. (App. 28a). Judge Noce, Memorandum at page 20, correctly ruled that Petitioner's statement were "speculative at best and insufficient to withstand summary judgment. Fed. R. Civ. P. 56(e)." Petitioner failed to appeal this issue and has, therefore, waived same. The Eighth Circuit agreed.

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15. Judge Noce ruled: "[A] determination of the case in the absence of Aetna will not subject Moore to the risk of inconsistent or double obligations." (A-26). This part of the ruling was not appealed by the Petitioner and is waived.

For these reasons this Court in making its determinations should not consider the affidavit nor the substantial majority of the facts recited in Petitioner's Brief and the Government's Brief, neither of which have any evidentiary basis.

CONCLUSION

WHEREFORE, for all of the foregoing reasons, it is respectfully submitted that the Eighth Circuit correctly affirmed Judge Noce granting of summary judgment for the Respondents and that its decision should be affirmed.

Respectfully submitted,

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